Handbook for Home Health Agencies

Chapter R-200 Policy and Procedures For Home Health Agencies

Illinois Department of Healthcare and Family Services

CHAPTER R-200

Home Health Agency Services

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FOREWORD

PURPOSE

This handbook has been prepared for the information and guidance of home health agency providers who provide items or services to participants in the Department's Medical Programs. It also provides information on the Department's requirements for provider participation and enrollment.

This handbook can be viewed on the Department's website at

http://www.hfs.illinois.gov/handbooks/chapter200.html

This handbook provides information regarding specific policies and procedures relating to home health agency services.

It is important that both the provider of service and the provider's billing personnel read all materials prior to initiating services to ensure a thorough understanding of the Department's Medical Programs policy and billing procedures. Revisions and supplements to the handbook will be released from time to time as operating experience and state or federal regulations require policy and procedure changes in the Department's Medical Programs. The updates will be posted to the Department's Web site at

http://www.hfs.illinois.gov/releases/

Providers will be held responsible for compliance with all policy and procedures contained herein.

Inquiries regarding coverage of a particular service or billing issues may be directed to the Bureau of Comprehensive Health Services at 1-877-782-5565.

CHAPTER R-200

HOME HEALTH AGENCY SERVICES

R-200 BASIC PROVISIONS

For consideration for payment by the Department for home health services, a provider enrolled for participation in the Department's Medical Programs must provide such services. Services provided must be in full compliance with both the general provisions contained in the Chapter 100, Handbook for Providers of Medical Services, General Policy and Procedures http://www.hfs.illinois.gov/handbooks/chapter100.html and the policy and procedures contained in this handbook. Exclusions and limitations are identified in specific topics contained herein.

The billing instructions contained within this handbook are specific to the Department's paper forms. Providers wishing to submit X12 or NCPDP electronic transactions must refer to Chapter 300, Handbook for Electronic Processing <http://www.hfs.illinois.gov/handbooks/chapter300.html>. Chapter 300 identifies information that is specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other healthcare programs funded or administered by the Illinois Department of Healthcare and Family Services.

R-201 PROVIDER PARTICIPATION

R-201.1 PARTICIPATION REQUIREMENTS

A proprietary or not-for-profit home health agency holding a valid license issued by the Illinois Department of Public Health (or meeting the requirements of the state in which the agency is located) with certification in the Medicare Program or has been designated as Medicare certifiable by the Department of Public Health, a licensed community health agency and health Department certified by the Department of Public Health is eligible to be considered for enrollment to participate in the Department's Medical Programs.

The provider must be enrolled for the specific category of service for which charges are to be made, i.e., Category 66 - Home Health Services.

A nursing agency approved by the University of Illinois at Chicago, Division of Specialized Care for Children, to provide services for children and adolescents less than 21 years of age, can enroll to provide in-home shift nursing services under the Nursing and Personal Care Services Program.

Procedure: The provider must complete and submit the following for each office site as defined by Medicare:

- Form HFS 2243 (Provider Enrollment/Application)
- Form HFS 1413 (Agreement for Participation)
- HCFA 1513 (Disclosure of ownership and controlling interest)
- W9 (Request for Taxpayer Identification Number)

These forms may be obtained from the Provider Participation Unit. E-mail requests for enrollment forms should be addressed to:

hfs.ppu@illinois.gov

Providers may also call the unit at 217-782-0538 or mail a request to:

Healthcare and Family Services
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

http://www.hfs.illinois.gov/enrollment/

The forms must be completed (printed in ink or typewritten), signed and dated in ink by the provider, and returned to the above address. The provider should retain a copy of the forms. The date on the application will be the effective date of enrollment unless the provider requests a specific enrollment date and it is approved by the Department.

Participation approval is not transferable - When there is a change in ownership, location, name, or a change in the Federal Employer's Identification Number, a new application for participation must be completed. Claims submitted by the new owner

using the prior owner's assigned provider number may result in recoupment of payments and other sanctions.

R-201.2 PARTICIPATION APPROVAL

When participation is approved, the provider will receive a computer-generated notification, the Provider Information Sheet, listing all data on the Department's computer files. The provider is to review this information for accuracy immediately upon receipt. For an explanation of the entries on the form, see Appendix R-3.

If all information is correct, the provider is to retain the Provider Information Sheet for subsequent use in completing claims (billing statements) to ensure that all identifying information required is an exact match to that in the Department files. If any of the information is incorrect, refer to Topic R-201.4.

R-201.3 PARTICIPATION DENIAL

When participation is denied, the provider will receive written notification of the reason for denial.

Within ten (10) calendar days after the date of this notice, the provider may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which the Department's action is being challenged. If such a request is not received within ten (10) calendar days, or is received, but later withdrawn, the Department's decision shall be a final and binding administrative determination. Department rules concerning the basis for denial of participation are set out in 89 Ill. Adm. Code 140.14. Department rules concerning the administrative hearing process are set out in 89 Ill. Adm. Code 104 Subpart C.

R-201.4 PROVIDER FILE MAINTENANCE

The information carried in the Department's files for participating providers must be maintained on a current basis. The provider and the Department share responsibility for keeping the file updated.

Provider Responsibility

The information contained on the Provider Information Sheet is the same as in the Department's files. Each time the provider receives a Provider Information Sheet it is to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be used by the provider in the preparation of claims; any inaccuracies found are to be corrected and the Department notified immediately.

Any time the provider effects a change that causes information on the Provider Information Sheet to become invalid the Department is to be notified. When possible, notification should be made in advance of a change.

Procedure: The provider is to line out the incorrect or changed data, enter the correct data, sign and date the Provider Information Sheet with an original signature on the line provided. Forward the corrected Provider Information Sheet to:

Healthcare and Family Services
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

Failure of a provider to properly notify the Department of corrections or changes may cause an interruption in participation and payments.

Department Responsibility

When there is a change in a provider's enrollment status or the provider submits a change the Department will generate an updated Provider Information Sheet reflecting the change and the effective date of the change. The updated sheet will be sent to the provider and to all payees listed if the payee address is different from the provider address.

R-202 HOME HEALTH AGENCY REIMBURSEMENT

When billing for services, the claim submitted for payment must include a diagnosis and the coding must reflect the actual services provided. Any payment received from a third-party payer, a program participant or other persons applicable to the provision of services must be reflected as a credit on any claim submitted to the Department bearing charges for those services or items. (Exception: Department co-payments when applicable are not to be reflected on the claim. Refer to Topic 114.1 for more information on patient cost sharing.)

Home Health Services are paid an all-inclusive per visit rate. Reimbursement for services such as mileage and standard medical equipment/supplies are included in this rate.

R-202.1 CHARGES

Charges billed to the Department must be the provider's usual and customary charge billed to the general public for the same service or item. Providers may only bill the Department after the service has been provided.

Charges for services provided to participants enrolled in a Managed Care Organization (MCO) must be billed to the MCO according to the contractual agreement with the MCO. Medicaid is not to be billed for services if the participant is enrolled in an MCO.

R-202.2 ELECTRONIC CLAIMS SUBMITTAL

Any services that do not require attachments or accompanying documentation may be billed electronically. Further information concerning electronic claims submittal can be found in Chapter 100, Topic 112.3 or Chapter 300, Topic 301.

> Providers billing electronically should take special note of the requirement that Form HFS 194-M-C, Billing Certification Form, must be signed and retained by the provider for a period of three (3) years from the date of the voucher. Failure to do so may result in revocation of the provider's right to bill electronically, recovery of monies or other adverse actions. Form HFS 194-M-C can be found on the last page of each Remittance Advice that reports the disposition of any electronic claims. Refer to Chapter 100, Topic 130.5 for further details.

Please note that the specifications for electronic claims billing are not the same as those for paper claims. Please follow the instructions for the medium being used. If a problem occurs with electronic billing, providers should contact the Department in the same manner as would be applicable to a paper claim. It may be necessary for providers to contact their software vendor if the Department determines that the service rejections are being caused by the submission of incorrect or invalid data.

R-202.3 CLAIM PREPARATION AND SUBMITTAL

Refer to Chapter 100, Topic 112, for general policy and procedures regarding claim submittal.

The Department uses a claim imaging system for scanning paper claims. The imaging system allows more efficient processing of paper claims and also allows attachments to be scanned. Refer to Appendix R-1 for technical guidelines to assist in preparing paper claims for processing. The Department offers a claim scanability/imaging evaluation. Please send sample claims with a request for evaluation to the following address.

Healthcare and Family Services
201 South Grand Avenue East
Second Floor - Data Preparation Unit
Springfield, Illinois 62763-0001
Attention: Provider/Image System Liaison

R-202.31 Claims Submittal

Form HFS 2212, Home Health Invoice, is to be used to submit charges. A copy of the form and detailed instructions for its completion are included in Appendices R-1 and R-1a.

All routine paper claims are to be submitted in a pre-addressed mailing envelope provided by the Department for this purpose, Form HFS 2246, Health Agency Invoice Envelope. Use of the pre-addressed envelope should ensure that billing statements arrive in their original condition and are properly routed for processing.

For a non-routine claim submittal, use Form HFS 2248, Special Handling Envelope. A non-routine claim is:

Any claim to which Form HFS 1411, Temporary MediPlan Card, is attached.

Any claim to which any other document is attached.

For electronic claims submittal, refer to Topic R-202.2 above. Non-routine claims may not be electronically submitted.

R-202.32 Claims Requiring Override by Department

A participant has Medicare as primary payer and Medicare denies the service, prior/post approval must be obtained. The Explanation of Medicare Benefits (EOMB), HFS 2212 and a cover letter requesting an override must be sent to billing staff.

If participant is admitted or discharged from a long term care facility during the certification period, the HFS 2212 must be submitted with a cover letter requesting an override to billing staff.

Claims that require an override should be mailed to:
Illinois Department of Healthcare and Family Services
P.O. Box 19115
Springfield, IL 62794-9115
Attn: Home Health Billing

R-202.4 PAYMENT

Payment made by the Department for allowable services will be made at the lower of the provider's usual and customary charge or the maximum rate as established by the Department.

Payment for in-home shift nursing for children under 21 years of age shall be at the Department's established hourly rate.

Refer to Chapter 100, Topics 130 and 132, for payment procedures utilized by the Department and General Appendix 8 for explanations of Remittance Advice detail provided to providers.

R-202.5 FEE SCHEDULE

Procedure codes and reimbursement rates for each home health provider are listed on the Provider Information Sheet. Any time changes in procedure codes or rates are made; the provider will receive an updated provider information sheet.

R-203 COVERED SERVICES

A covered service is a service for which payment can be made by the Department. Refer to Chapter 100, Topic 103, for a general list of covered services.

> Services are covered only when provided in accordance with the limitations and requirements described in the individual topics within this handbook.

Payment will be made only for home health agency services provided on an intermittent, short-term basis by a Medicare certified or Medicare certifiable home health agency, a licensed community health agency or a certified health Department. Services for a participant must be provided in the individual's place of residence and aimed at facilitating the transition from a more acute level of care to the home or to prevent the necessity for a more acute level of care. A participant does not have to be homebound to qualify for home health services. Services provided should be of a curative or rehabilitative nature and demonstrate progress toward short term goals outlined in a plan of care. Services shall be provided for individuals upon direct order of a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Advanced Practice Nurse (APN) or Physician Assistant (PA) and in accordance with a plan of care (CMS/HCFA 485) established by the practitioner and reviewed by the practitioner at least every sixty (60) days. For purposes of this section, a residence does not include a hospital or skilled nursing facility and only includes an intermediate care facility for the mentally retarded to the extent home health services are not required to be provided under 89 Ill.Adm.Code Part 144.

Shift nursing care in the home for the purposes of caring for a participant under 21 years of age who has extensive medical needs and requires ongoing skilled nursing care.

R-203.1 Home Health Agency Services

Home Health Agency services include skilled nursing services; speech, physical and occupational therapy services; and home health aide services, aimed at rehabilitation and attainment of short-term goals as outlined in the plan of care.

Services must be provided in accordance with a plan of care established and approved by the attending physician and reviewed by the physician at least every sixty (60) days. Services shall be provided to facilitate and support the individual in transitioning from a more acute level of care, e.g., hospital, long term care facility, etc., to the home environment or to prevent the necessity for a more acute level of care.

One home assessment visit may be made without prior approval of the Department for the purpose of assessing needs and developing a plan of care in conjunction with the attending physician.

When an individual is in need of home health services following discharge from an acute care or rehabilitation hospital with an inpatient stay of 24 hours or more and requires daily visits or less within the first sixty (60) calendar days of discharge may be provided without prior approval when services are initiated within fourteen (14) days of discharge. If the participant's needs require more than one skilled nursing visit per day, prior approval is required.

All in-home shift nursing requires prior approval. Refer to Topic 211 for the prior approval requirements.

All Home Health services for DCFS children following an inpatient admission require prior approval. DCFS case numbers begin with "98."

R-203.2 Definitions of Home Health Agency Services

Home Assessment Visit - A service provided during the initial home visit by a registered nurse to assess the recipient's condition and determine the level of care needed based on information received from the attending physician.

Skilled Nursing Services – Services that are ordered by the physician and are provided in a participant's home by licensed nursing personnel. Services include initiation and implementation of restorative/palliative nursing procedures, coordination of plan of care and patient/family instruction.

Occupational Therapy Services - Services which are ordered by the attending physician and given by a qualified occupational therapist or occupational therapy assistant under the supervision of an occupational therapist for the purpose of developing and improving the physical skills required to engage in activities of daily living.

Physical Therapy Services - Physical therapy services ordered by a physician and provided to a participant by a qualified physical therapist or physical therapy assistant under the supervision of a physical therapist. These services include, but are not limited to, range of motion exercises, positioning, transfer activities, gait training, use of assistive devices for physical mobility and dexterity.

Speech Therapy Services - Services ordered by the attending physician for individuals with speech disorders, and provided to a participant by a qualified speech pathologist and/or speech assistant under the supervision of a speech pathologist for individuals with speech disorders which include diagnostic, screening, preventive or corrective services.

Home Health Aide Services - Services that are a part of the treatment plan outlined by the attending physician and are carried out under the supervision of a registered nurse. In those circumstances where the patient's physician has ordered only therapy services, the appropriate therapist (physical therapist, speech-language pathologist or occupational therapist) may supervise the home health aide. Services include the performance of simple procedures as an extension of therapeutic

services; ambulation and exercise; personal care; household services essential to healthcare at home; assistance with medications that are ordinarily self-administered; and reporting changes in a patient's condition and needs to the registered nurse or appropriate therapist.

Nursing and Personal Care Services – Medicaid eligible participants who are under the age of 21 may receive medically necessary in-home shift nursing and personal care services provided by an RN, LPN or Certified Nurses Aide under the direction of a qualified home health agency.

Department of Children and Family Services (DCFS) In-Home Shift Nursing Program – Medicaid eligible participants who are under the age of 21 may receive medically necessary in-home shift nursing provided by an RN, LPN or Home Health Aide under the direction of a qualified home health agency. Prior approval requests and required documentation must be submitted to the Department of Children and Family Services, Division of Service Intervention, Office of Health Services who will then forward to our Department for medical review and processing.

R-204 NON-COVERED SERVICES

Services for which medical necessity is not clearly established are not covered by the Department's Medical Programs. Refer to Chapter 100, Topic 104, for a general list of non-covered services.

The following home health agency services are excluded from coverage in the Department's Medical Programs. Payment cannot be made for the provision of these services:

- Services ordered by terminated or barred providers
- Services which are the responsibility of local government units (e.g., city or county health Departments)
- Services of a medical social worker
- Services of a homemaker
- Prescription drugs
  - May be covered through the pharmacy program
- Standard medical supplies, equipment, etc., which are not a part of the agency's per visit charge
  - Non-standard medical supplies, equipment, etc., may be covered through the durable medical equipment program
- Routine care of the newborn
- Routine post-partum care
- Infant stimulation
- Infant/mother bonding/parenting skills
- Similar services provided by more than one home health agency

If the participant is in need of homemaker or social services, the agency may contact the Department of Human Services' office in the participant's county of residence for assistance in obtaining the needed services.

A home health agency may not provide services to a resident in a Supportive Living Facility (SLF) that are offered by the SLF.

Home health services are <u>not</u> covered for participants in the Transitional Assistance Program and for adult participants in the Family and Children Assistance Program in the city of Chicago (formerly general assistance program) unless they have a terminal diagnosis.

R-205 RECORD REQUIREMENTS

The Department regards the maintenance of adequate records essential for the delivery of quality medical care. In addition, providers should be aware that medical records are key documents for post-payment audits. Refer to Chapter 100, Topic 110 for record requirements applicable to all providers.

> In the absence of proper and complete medical records, no payment will be made and payments previously made will be recouped. Lack of records or falsification of records may also be cause for a referral to the appropriate law enforcement agency for further action.

= Providers of intermittent home health services and in-home shift nursing must maintain records in compliance with the requirements set forth in 77 Ill. Admin. Code Part 245 and, if applicable, the University of Illinois, Division of Specialized Care for Children Guidelines for Nursing Agencies.

The minimum record requirements satisfying Department standards for home health services are as follows:

- Identification of the recipient, i.e., name and address, case identification number, age;
- Complete and current diagnosis;
- Name of ordering practitioner (we will accept orders from an MD, DO, APN or PA);
- Copy of physician orders and treatment plan (CMS/HCFA 485) for each sixty (60)-day certification period;
- Copy of prior authorization request, when applicable; and
- Initial evaluation and progress reports that document progress toward treatment plan goals.

R-211 PRIOR APPROVAL PROCESS

Prior to the provision of certain services, approval must be obtained from the Department.

> If charges are submitted for services that require prior approval and approval was not obtained, payment will not be made for services as billed. See Chapter 100, Topic 111, for a general discussion of prior approval provisions.

The Department will not give prior approval for an item or service if a less expensive item or service is considered appropriate to meet the patient's need.

> Prior approval to provide services does not include any determination of the patient's eligibility. When prior approval is given, it is the provider's responsibility to verify the patient's eligibility on the date of service.

A request for prior approval must be submitted in advance in order to maintain continuity of services. Refer to Chapter 100, Topic 111, for a general discussion of prior approval provisions.

Prior approval requirements do not apply in situations in which services are provided to:

- an individual needing daily visits or less within a sixty (60) calendar day period immediately following inpatient discharge from an acute care or rehabilitation hospital, if care started within fourteen (14) days;
- an individual eligible for Medicare Part A or Part B benefits and the service is covered in the Medicare Program.

Prior approval must be requested for recipients who:

- Require continuation of services after the initial sixty (60) calendar day period following hospital discharge;
- Require continuation of services beyond the initial approval period;
- Have exhausted Medicare benefits;
- Are eligible for Medicare benefits, but the needed services are non-covered by Medicare;
- Have primary insurance coverage that will pay a portion but a balance is still remaining;
- Require more than one skilled nurse visit per day;
- Require home health services following an inpatient admission with a recipient ID number and/or case number beginning with "98;"
- Require in-home shift nursing care pre-approved by the Department of Children and Family Services;
- Require in-home shift nursing care pre-approved by the Department of Healthcare and Family Services for the Nursing and Personal Care Program.

All requests for prior approval after the sixty (60) day period following hospital discharge must contain a copy of the plan of care (CMS/HCFA 485) for the sixty (60) day period requested.

R-211.1 PRIOR APPROVAL REQUESTS

Prior approval requests must contain enough information for Department staff to make a well-informed decision on medical necessity, appropriateness and anticipated patient benefits of the service.

> The single most common reason for denial of prior approval requests is lack of adequate information upon which to make an informed decision.

The exact information needed will vary depending on the service requested and the medical condition of the patient, but the process described below is designed to cover the general information that is needed for all requests.

Prior approval requests may be submitted to the Department by mail, fax, telephone, or electronically via the REV system.

By Mail:

The supplying provider is to complete form HFS 1409, Prior Approval Request, when requesting covered services. A sample copy of form HFS 1409 and instructions for its completion are found in Appendices R-2 and R-2a.

All HFS 1409 forms must be signed in ink by the supplying provider or his or her designee. The form HFS 1409 must be accompanied by the following documentation.

- current signed and dated plan of care (CMS/HCFA 485)
- addendum order, if applicable
- copy of the initial evaluation or progress summary for therapy services.

By FAX:

Complete Form HFS 1409, following the procedures described above for mailed requests. The completed form, the plan of care (CMS/HCFA 485), addendum order if applicable and other associated documents can be faxed to the number shown below. Providers should review the documents before faxing to ensure that they will be legible upon receipt. Colored documents, including the pink Form HFS 1409 often do not fax clearly. The Department recommends that such documents be photocopied and that the copy be faxed.

The fax number for prior approval requests is 217-524-0099. This fax is available Monday through Friday, 8:30 AM – 5:00 PM, excepting holidays.

By Telephone:

When prior approval is requested by telephone, the request will be data entered by staff at the following telephone number:

1-877-782-5565 Select Option 5 from the automated menu

The number is available Monday through Friday, 8:30 AM to 5:00 PM, excepting holidays.

The caller must be prepared to give all the information requested on the HFS 1409.

The provider is responsible for having a verbal order from the MD, DO, APN or PA upon initiation of care and services. However in order to request prior approval the home health agency should have a completed plan of care (485) signed by the nurse on Line 23 and signed or un-signed by the physician which must be faxed to the Prior Approval Unit to finalize the prior approval process. If the Prior Approval Unit does not receive the 485, when the request is reviewed, additional information will be requested which delays processing.

Once the provider receives the signed 485, it must be kept in the provider's records for auditing purposes.

Electronically:

The provider via any of the Department's approved Recipient Eligibility Verification (REV) vendors may electronically submit prior approval requests into the Department's prior approval system. For more information on the REV system, refer to Handbook for Providers of Medical Services, Chapter 100 General Policies and Procedures, Topic 131.2. For a listing of approved REV vendors, refer to http://www.hfs.illinois.gov/rev/

The provider must mail or fax the plan of care, addendum order and therapy documentation in support of an electronically submitted request, this information should be noted in the comments section of the electronic request. In addition, the mailed or faxed materials should clearly indicate that the prior approval request has been electronically submitted. Failure to make these notations will make it more difficult for the Department to match the documentation with the prior approval request and thus may delay a decision on the request.

The Department reserves the right to request proof of a valid physician order or other supporting documentation before approval is granted.

R-211.2 APPROVALS FOR LONG TERM NEED

Intermittent Services

At the Department's discretion, the following services provided on an intermittent basis may be given approval periods beyond sixty (60) days.

- Urinary catheter maintenance - up to two (2) visits monthly for six (6) months.
- Vitamin B 12 injections – one (1) visit per month for six (6) months.
- Maintenance of venous access devices – one (1) visit per month for six (6) months.
- =Synagis injections – Please refer to the pharmacy guidelines located on the Department's Web site at http://www.hfs.illinois.gov/pharmacy/guidelines.html

The Department will review the 485 to verify the number of visits the MD ordered and will approve lesser amounts if applicable. If an agency does any additional visits during the above listed periods, a paper review with an addendum order to cover the additional visits must be submitted.

In-home Shift Nursing Services for Participants Under 21 Years of Age

= For in-home shift nursing services, approvals will be granted for the first and second sixty-day certification periods. Upon the third submittal for re-certification a six-month approval may be granted after the medical review process is completed. For ongoing in-home shift nursing services a six-month approval may be granted after medical review. The Department reserves the right to reduce the approval certification time period when medically appropriate.

R-211.3 APPROVAL OF SERVICE

If the service requested is approved, the provider and the patient will receive a computer-generated letter, form HFS 3076A, Prior Approval Notification, listing the approved services. Upon receipt of the Prior Approval Notification, the service(s) may be billed.

Any changes/corrections needed to the prior approval notification HFS 3076A, must be submitted as a review via mail or fax with supporting documentation to the prior approval unit.

If a patient is admitted to the inpatient hospital setting within the dates of service that have been approved, you must notify the Department in writing to end the prior approval on the date of admission.

R-211.4 DENIAL OF SERVICE

If the service requested is denied, a computer-generated Form HFS 3076C, citing the denial reason, will be sent to the patient and the provider. The provider cannot file an appeal of the denial. If the provider obtains additional information that could result in a reversal of the denial, the provider may submit a new prior approval request with the supporting medical information attached.

R-211.5 TIMELINES

The Department is obligated to make a decision on prior approval requests within specified time frames. In general, decisions must be made within twenty-one (21) days of receipt of a properly completed request, with exceptions as described below. If no decision has been made within the twenty-one (21)-day period, the service is automatically approved. If a service has been automatically approved, reimbursement will be made at the provider's charge or the Department's maximum rate, whichever is less.

If the request is incomplete or requires further information to be properly considered, the Department may request additional information from either the supplying provider or the physician who ordered the service. If additional information is requested within fourteen (14) days of receipt of the prior approval request, the twenty-one (21)-day period stops. When the required information is received, a new twenty-one (21)-day period begins.

The provider can request status of a prior approval after thirty (30) days from the Department's receipt date. This can be done via mail, fax or by calling the prior approval unit at 1-877-782-5565 Option 5.

R-211.6 POST APPROVALS

When requesting post approval for home health visits, the Department requires documentation indicating the dates the visits were completed during the requested time frame. Post approval may be granted upon consideration of individual circumstances, such as:

- Determination of the patient's eligibility for the Medical Assistance Program or for All Kids was delayed or approval of the application had not been issued as of the date of service. In such a case, the post approval request must be received no later than ninety (90) days following the Department's Notice of Decision approving the patient's application.

- There was a reasonable expectation that other third party resources would cover the service and those third parties denied payment after the service was provided. To be considered under this exception, documentation that the provider billed a third party payor within six months following the date of service, as well as a copy of the denial from that third party must be supplied with the request for approval. The request for post approval must be received no later than ninety (90) days from the date of final adjudication by the third party.

- The patient did not inform the provider of his or her eligibility for Medical Assistance or All Kids. In such a case, the post approval request must be received no later than six (6) months following the date of service to be considered for payment. To be considered under this exception, documentation of the provider's dated, private-pay bills or collection correspondence, that were

addressed and mailed to the patient each month following the date of service, must be supplied with the request for approval.

To be eligible for post approval consideration, all the normal requirements for prior approval of the service must be met, and the post approval requests must be received by the Department no later than ninety (90) days from the date services are provided or within the time frames identified above.